Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DALLAS INJECTION AND DIAGNOSTICS 5445 LA SIERRA DRIVE DALLAS TX 75231	MFDR Tracking #: M4-05-B649-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "no MAR/fair and reasonable." "Fee schedule." "fair and reasonable." [sic]

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $1,700.54

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "**99499, A4550, A4649, A6215, A4300, A4305, J3490 (xylocaine), 99070**: It is this carrier's position that NO reimbursement is due for these codes as reimbursement for the expenses associated with the services billed, under codes 62311 and 76005, were made in the non-facility reimbursement rate paid for codes 62311 and 76005." "The surgeon reported the services in dispute were performed in a doctor's office (Exhibit 3) and the surgeon was reimbursed at the non-facility rate for codes 62311 and 76005, which includes practice expense. The requester reported the services in dispute were provided in an 'Other Place of Service'[1] The requester (Charles Willis, MD, under whose license Dallas Injection is billing) was reimbursed at the non-facility rate for code 76005-TC[2]. (Exhibit 3)." "The *Medicare RBRVS: The Physician's Guide* 2003 defines **Practice expense as, 'The cost of physician practice overhead, including rent, staff salaries and benefits, medical equipment, and supplies; one of three resource cost components included in the formula for computing Medicare payment schedule amounts.'[3]** "**Therefore, the facility, surgical tray, and supplies were reimbursed under reimbursement for practice expense under code 62311.**" "Additionally, it is this carrier's position the requester improperly billed with code A4300 (disposable drug delivery system, flow rate of 50ml or less per hour), code A4300 (implantable access catheter), and code A4221 (supplies for maintenance of drug infusion catheter for week). The documentation does not support that such devices were used or necessary. (Exhibit 3) However it they had been used it is this carrier's position that code A4300 is global to the reimbursement made to the surgeon for the procedure." "**A4550:** No reimbursement is due per Medicare policy. Medicare does not provide for the reimbursement of a surgical tray." "Trailblazer Medicare Part B Newletter 02-022, page 24, states in part: 'Surgical Tray…Effective for dates of service on or after January 1, 2002, code A4550, surgical trays, will no longer be valid for Medicare." "**J7040, J2912, J3301, J3490 (Marcaine), J3490 (Diprivan), A4611:** Upon review, reimbursement was made for codes J7040, J2912, J3301, J3490 (Marcaine), J3490 (Diprivan), A4611. (Exhibit 1)

Principal Documentation:

1. DWC 60 Package
2. EOBs
3. Medical Bill

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
9/8/2004	99499 – Recovery Room X2	Not Applicable	$600.00	$0.00
9/8/2004	76005-TC	Not Applicable	$136.74	$0.00
9/8/2004	A4300	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
9/8/2004	A4649	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
9/8/2004	J2912	Not Applicable	$0.55	$0.00
9/8/2004	J7040	Not Applicable	$7.05	$0.00
9/8/2004	A4305	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
9/8/2004	J3301	Not Applicable	$80.00	$0.00
9/8/2004	A4550	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
9/8/2004	J3490	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
9/8/2004	J3490	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
9/8/2004	J3490	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
9/8/2004	A4641	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
9/8/2004	99070	The requestor withdrew this service on 6/17/2008	$0.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on August 19, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 26, 2007 to send additional documentation relevant to the fee dispute as set forth in the rule.

2. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for professional medical treatment and services.

3. Division rule at 28 TAC §134.401, effective August 1, 1997, sets out the reimbursement for inpatient hospital services.

4. On June 17, 2008, the requestor's representative, Judith Guerra, submitted a withdrawal for all DME codes that do not have a maximum allowable reimbursement (MAR). Therefore, HCPCS codes A4300, A4649, A4305, A4550, J3490 A4641 and 99070 will not be considered further in this decision.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 10/14/2004

   - F, YF- Reduced or denied in accordance with the appropriate fee guideline ground rule and/or maximum allowable reimbursement (MAR). Please refer to TWCC Rule 134.402 that went into effect on 9/1/04.

   Explanation of benefits dated 2/3/2005

   - F- Please refer to TWCC Rule 134.402 that went into effect on 9/1/04.
   - 891-The insurance company is reducing or denying payment after reconsidering a bill.

   Explanation of benefits dated 9/2/2005

   - Please refer to TWCC Rule 134.402 that went into effect on 9/1/04.
   - CAC-W1-Workers Compensation State Fee Schedule Adjustment.
   - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 891-The insurance company is reducing or denying payment after reconsidering a bill.

- 920-Reimbursement is being allowed based upon a dispute.

Issues

1. What is the applicable rule for reimbursement?
2. Is the requestor entitled to reimbursement for CPT code 99499?
3. Is the requestor entitled to reimbursement for CPT code 76005-TC?
4. Is the requestor entitled to reimbursement for HCPCS code J2912?
5. Is the requestor entitled to reimbursement for HCPCS code J7040?
6. Is the requestor entitled to reimbursement for HCPCS code J3301?

Findings

1. Division rule at 28 TAC §134.202(a)(1) states "This section applies to professional medical services (health care other than prescription drugs or medicine, and the facility services of a hospital or other health care facility) provided in the Texas Workers' Compensation system."

   Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, states "Ambulatory/outpatient surgical care is not covered by this guideline..."

   Division rule at 28 TAC §134.401(b)(1)(A), effective August 1, 1997, states "A health care facility that provides inpatient or outpatient services delivered to patients experiencing acute illness or trauma as licensed by the Texas Department of Health (TDH) as a General or Special Hospital Type."

2. CPT code 99499 is described as "Unlisted evaluation and management service". The requestor noted on the medical bill that CPT code 99499 was billed for "recovery room" charges.

   The respondent states in the position summary that "It is this carrier's position that NO reimbursement is due for these codes as reimbursement for the expenses associated with the services billed, under codes 62311 and 76005, were made in the non-facility reimbursement rate paid for codes 62311 and 76005." "The surgeon reported the services in dispute were performed in a doctor's office (Exhibit 3) and the surgeon was reimbursed at the non-facility rate for codes 62311 and 76005, which includes practice expense. The requester reported the services in dispute were provided in an 'Other Place of Service'[1] The requester (Charles Willis, MD, under whose license Dallas Injection is billing) was reimbursed at the non-facility rate for code 76005-TC[2]. (Exhibit 3)."

   The Division reviewed the disputed medical bill that indicates the place of service for the procedure was "99". Per Medicare "99 - Other Place of Service not identified above." The requestor wrote in the letter requesting reconsideration of payment that "All procedures were performed in an independent free standing injection center."

   TDH does not list a facility license for Dallas Injection and Diagnostic. Therefore, the requestor is not a licensed hospital that may be reimbursed for facility charges. As a result, reimbursement is not recommended for CPT code 99499.

3. CPT code 76005-TC is described as "Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction." The requestor is billing for the technical component of the procedure. The technical component is included in the facility charges for the procedure. The requestor is not a licensed facility per TDH; therefore, reimbursement is not recommended.

4. HCPCS code J2912 is described as "Sodium chloride injection." A review of the *Table of Disputed Services* indicates a disputed amount of $0.55. The respondent submitted an EOB dated 9/2/2005 that indicates reimbursement of $0.55 was made. The Division finds therefore that no additional amount is due.

5. HCPCS code J7040 is described as "Infusion, normal saline solution, sterile (500 ml=1 unit)." A review of the *Table of Disputed Services* indicates a disputed amount of $7.05. The respondent submitted an EOB dated 9/2/2005 that indicates reimbursement of $7.05 was made. The Division finds therefore that no additional amount is due.

6. HCPCS code J3301 is described as "Injection, triamcinolone acetonide, not otherwise specified, 10 mg." A review of the *Table of Disputed Services* indicates a disputed amount of $80.00. The respondent submitted an EOB dated 9/2/2005 that indicates reimbursement of $14.30 was made. However, the Division finds that reimbursement for a packaged service cannot be recommended. As a result the amount ordered is $0.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not supports the reimbursement amount sought by the requestor. For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	**8/11/2010**
		Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.